STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155794	B. WING		03/18/2013
NAME OF F	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
0.7.0.4.7.5.	ODD DETIDEMEN	T.I.O.		SLEBE ST	
STRATE	ORD RETIREMEN	I LLC	CARIMI	EL, IN 46032	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F000000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFECTIVE 1)	DATE
1 000000					
	This visit was	for the Recertification	F000000		
		ensure Survey. This visit			
	included the Ir				
	Complaint IN0	0122963.			
	Complaint IN0	0122963-			
	Substantiated	with no deficiencies.			
	•	March 12, 13, 14, 15,			
	and 18, 2013.				
	Facility number				
	Provider numb				
	AIM number :	N/A			
	Survey team:	otas DN TO			
	Michelle Hoste				
	Janet Stanton	, KIN			
	Census bed ty	vno:			
	SNF: 10	pe.			
	Residential: 9	1			
	Total: 101	•			
	rotali ro				
	Census payor	type:			
	Medicare: 4	71			
	Other: 6				
	Residential: 9	1			
	Total : 101				
	Residental sar	mple: 7			
	These deficier	ncies reflect state			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155794	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 8/2013
	PROVIDER OR SUPPLIER ORD RETIREMENT LLC	2460 G	ADDRESS, CITY, STATE, ZIP CO LEBE ST EL, IN 46032	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	findings cited in accordance with 410 IAC 16.2.				
	Quality Review completed by Tammy Alley RN on March 21, 2013.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CR9N11

Facility ID: 011151

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155794			(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/18/2013
		1557 84	B. WING		00/10/2010
	ROVIDER OR SUPPLIER		2460 G	ADDRESS, CITY, STATE, ZIP CODE LEBE ST EL, IN 46032	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
F000225	483.13(c)(1)(ii)-(ii		1710		DATE
SS=D	INVESTIGATE/R	EPORT			
	ALLEGATIONS/II				
	have been found	not employ individuals who			
		streating residents by a			
		ave had a finding entered			
		se aide registry concerning			
		nistreatment of residents or			
		of their property; and report			
	any knowledge it	has of actions by a court of			
	law against an en	nployee, which would			
	indicate unfitness	for service as a nurse aide			
		aff to the State nurse aide			
	registry or licensing	ng authorities.			
	violations involvin abuse, including i and misappropria are reported imme administrator of the officials in accord through established	ensure that all alleged ag mistreatment, neglect, or njuries of unknown source tion of resident property ediately to the ne facility and to other ance with State law ed procedures (including to and certification agency).			
	The facility must h	nave evidence that all			
	alleged violations				
	investigated, and	must prevent further			
	potential abuse w	hile the investigation is in			
	progress.				
	reported to the ac designated repres officials in accord (including to the S certification agend the incident, and	sentative and to other ance with State law			
		rd review and interview	F000225	What corrective action will b	04/17/2013

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Event ID: CR9N11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	I		00	COMPL	ETED
		155794	A. BUII			03/18/	
		1	B. WIN				
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					LEBE ST		
STRATF	ORD RETIREMENT	T LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the facility failed to ensure verbal				taken by the facility? The		
	abuse was imn	nediately reported for 1			internal investigation complete	ed	
		s of verbal abuse for 1			by the Administrator did not		
		CLI (Quality Care Life			substantiate the allegation of		
	Indicator) crite	•			abuse regarding resident #1.		
	,	na ioi abuse.			However, the reporting of the		
	(Resident #1)				abuse by the staff to the Administrator did not occur with	thin	
					the required timeframe. All sta		
	Findings:				will be educated by the	un	
					Administrator regarding the		
	During an interview with Resident #1				Abuse Prohibition Policy and		
	on 3/11/13 at 11 A.M., he indicated				Procedure by 4-17-13. All nev	N	
		-			staff will be educated regardin		
	that staff had y	elled at film.			the Abuse Prohibition Policy a	ind	
					Procedure during general		
	A request was	made of the			orientation and annually		
	Administrator f	or an investigation of			thereafter. All allegations of		
	allegation of al	ouse related to			abuse will be reported		
		n 3/13/13 at 3:00 p.m.,			immediately to their superviso		
		ded 3/13/13 at 3:45			and Administrator. The perso	n	
	· ·	dea 0/10/10 at 0.40			suspected of abuse will be		
	p.m.				suspended immediately pendi investigation. The investigation		
					will be initiated immediately by		
	In an interview	with the Administrator			Administrator following the	, uic	
	on 3/14/13 at 3	3:45 p.m., she indicated			allegation. The Social Service	ż	
	the staff did no	t report immediately to			Director will include times of	-	
		ninistrator or other			resident interviews to her resid	dent	
	staff.				abuse questionnaire for future		
	otan.				investigations. How will the		
	lm 4h = ! 4!	tion for Desident 44			facility identify other residen		
		ation for Resident #1			having the potential to be		
	· ·	he resident indicated			affected by the same practic		
	he had been ve	erbally threatened at by			and what corrective action w	<u>/ill</u>	
	staff on 12/26/	12. The investigation			be taken? All residents have		
	indicated the A	dministrator was not			potential to be affected by the		
		nediately by LPN #2,			alleged deficient practice.		
	l .	this concern in nursing			Criminal background and		
		•			reference checks have been	e	
	notes on 12/26	0/ IZ.			competed on all staff. All staff	lliw	
	Ī				be re-educated on our Abuse		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155794	B. WIN			03/18/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹					
OTD ATE		T.I. C			LEBE ST		
SIKAIR	ORD RETIREMENT	ILLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The nursing no	ote entry dated			Prohibition Policy and Procedu	ıre	
	_	00 p.m., indicated,			by 4/17/13. All new hires will b	oe .	
		nt) stating CNA			educated during general		
	•	,			orientation and then annually		
	(Certified Nurs	· ,			thereafter. All active clinical		
	threatened him	1"			records will be audited for		
					documentation referring to	415.04	
	The investigati	on completed on			possible abuse and to ensure		
	1/3/13 for the a	allegation of verbal			the Abuse Prohibition Policy a Procedure was followed. Wh		
		complete. The			measures will be put into pla		
		nent from LPN #2 did			to ensure the practice does r		
		e full name of CNA #1			recur? The DON will review the		
					24 hour report and nurses note		
	who reportedly threatened Resident				days per week as part of her	30 0	
		nent from CNA #2 also			routine. She will bring any		
	did not include	the name of the			identified issues to the next		
	alleged perpeti	rator. The information			scheduled morning manageme	ent	
	gathered by So	ocial Services did not			interdisciplinary meeting for		
	include the time	es when she			review and recommendations	for	
		e other residents.			follow-up. How will the		
		outer residents.			corrective action be monitore		
	The feether did	matimalisale assistance			to ensure the deficient practi	ce	
	,	not include evidence			does not recur and what QA		
	•	of CNA #1 to ensure			will be put into place? The		
	she was not wo	orking while the			Administrator and DON will bri	•	
	allegation of ve	erbal abuse was being			the results of the reviews to the		
	investigated.				monthly QA Committee meetir	ıg	
	J				for review and		
	3.1-28(2)(c)				recommendations. Any recommendation made by the		
	` ' ' '				committee will be followed up	hv	
	3.1-28(2)(d)				the Administrator and DON an	,	
					the results will be brought to the	-	
					next scheduled QA Committee		
					meeting. This will continue on		
					ongoing basis.		

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Event ID: CR9N11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155794				03/18/	2013
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER						
0.75.4.75	ODD DETIDEMENT	-110			LEBE ST		
STRAIF	ORD RETIREMENT	LLC		CARIME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1.2	DATE
F000226	483.13(c)						
SS=D	DEVELOP/IMPLN	MENT ABUSE/NEGLECT,					
	ETC POLICIES						
		develop and implement					
	•	nd procedures that prohibit					
		glect, and abuse of					
		sappropriation of resident					
	property.						0.4/4.7/2.04.0
	Based on recor		F00	0226			04/17/2013
	interview, the fa	acility failed to ensure			What corrective action will be		
	their abuse pro	hibition policy was			taken by the facility?		
	implemented for	or 1 of 1 allegations of					
	•	or 1 who met the QCLI			The internal investigation completed	l t	
		ife Indicator) criteria			by the Administrator did not		
	for abuse. (Re				substantiate the allegation of abuse		
	ioi abuse. (Re	sident #1)			regarding resident #1. However,		
					the reporting of the abuse by the		
	Findings:				staff to the Administrator did not		
					occur within the required		
	During an inter	view with Resident #1			timeframe. All staff will be educated	d	
	on 3/11/13 at 1	1 A.M., he indicated			by the Administrator regarding the		
	that staff had y	•			Abuse Prohibition Policy and		
					Procedure by 4-17-13. All new staff		
	A request was	made of the			will be educated regarding the		
	A request was				Abuse Prohibition Policy and		
		or an investigation of			Procedure during general		
	allegation of ab				orientation and annually		
	Resident #1 on	i 3/13/13 at 3:00 p.m.,			thereafter. All allegations of abuse		
	and was provid	led 3/13/13 at 3:45			will be reported immediately to thei supervisor and Administrator. The	1.	
	p.m.				person suspected of abuse will be		
	•				suspended immediately pending		
	In an interview	with the Administrator			investigation. The investigation will		
		:45 p.m., she indicated			be initiated immediately by the	ļ	
		•			Administrator following the	ļ	
		t report immediately to			allegation. The Social Service		
		ninistrator or other			Director will include times of		
	staff.				resident interviews to her resident	ļ	
					abuse questionnaire for future		
	In the investiga	ition for Resident #1			investigations.	ļ	
	3-		1			Į.	

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Event ID: CR9N11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MU		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155794	B. WIN			03/18/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		2460 G	LEBE ST	
STRATF	ORD RETIREMEN	TLLC		CARMEL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	· ·	he resident indicated			l	
	he had been v	erbally threatened at by			How will the facility identify other	
	staff on 12/26/	12. The investigation			residents having the potential to b	<u>e</u>
	indicated the A	dministrator was not			affected by the same practice and	
	reported to imr	mediately by LPN #2,			what corrective action will be	
	•	this concern in nursing			taken?	
	notes on 12/26/12.				All residents have the potential to b	ne.
		·· · - ·			affected by the alleged deficient	
	The nureing po	ote entry dated			practice. Criminal background and	
	The nursing note entry dated				reference checks have been	
	12/26/12 at 8:00 p.m., indicated,				competed on all staff. All staff will	
	"Res (resident) stating CNA				be re-educated on our Abuse	
	(Certified Nursing Assistant)				Prohibition Policy and Procedure by	,
	threatened him"				4/17/13. All new hires will be	
					educated during general orientation	ı
	The policy for a	abuse dated 11/1/12,			and then annually thereafter. All	
	provided by the	e DON on 3/15/13,			active clinical records will be audite	d
	indicated, "5	.1 Anyone who			for documentation referring to	
		ncident of suspected			possible abuse and to ensure that	
		the incident to his/her			the Abuse Prohibition Policy and	
	-	nediately, 5.1.1 The			Procedure was followed.	
	· •	risor will report the			What measures will be put into	
	•	•			What measures will be put into place to ensure the practice does	
	•	se immediately to the			not recur?	
		or designee and other				
		ordance with state			The DON will review the 24 hour	
	law"				report and nurses notes 5 days per	
					week as part of her routine. She wi	II
	3.1-28(a)				bring any identified issues to the	
					next scheduled morning	
					management interdisciplinary	
					meeting for review and	
					recommendations for follow-up.	
					How will the corrective action be	
					monitored to ensure the deficient	
					practice does not recur and what	
					QA will be put into place?	
			1		l 	1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155794		A. BUILDING B. WING	00	COMPLETED 03/18/2013			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE COMPLETION		
				The Administrator and DON was bring the results of the review the monthly QA Committee of for review and recommendation made be committee will be followed up the Administrator and DON at results will be brought to the scheduled QA Committee me This will continue on an ongoing basis.	vs to neeting ions. by the p by nd the next eting.		
				1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155794	B. WING		03/18/2013
	ROVIDER OR SUPPLIER		2460 G	ADDRESS, CITY, STATE, ZIP CODE LEBE ST EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROUDERS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000279 SS=D	PLANS A facility must us assessment to de the resident's corr The facility must care plan for each measurable object meet a resident's mental and psychidentified in the compact of the care plan must hat are to be furnithe resident's high mental, and psychemical, and psychemical mental, and psychemical mental, and psychemical mental, and psychemical mental	e the results of the evelop, review and revise imprehensive plan of care. develop a comprehensive in resident that includes ctives and timetables to imedical, nursing, and inosocial needs that are omprehensive assessment. Just describe the services inshed to attain or maintain thest practicable physical, thosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, it to refuse treatment under view and record	F000279	What corrective action will be taken by the facility? The	oe 04/17/2013
	Care Plan addi (automatic imp defibrillator) de for 2 of 16 reco development of of 16. Resider Findings include 1. The clinical #26 was review 10:48 A.M. Th	ility failed to develop a ressing an AICD plantable cardiac evice and dental care ords reviewed for a fraceplans in a sample at #26 and # 27) de: record for Resident eved on 3/15/13 at the resident was a facility on 2/25/13 with		current care plan has been updated to reflect the AICD for resident #26. A follow-up appointment has been schedu with the cardiologist on April 8 2013. The current care plan has been updated to address the current dental concerns for resident #27. A follow-up den appointment has been put on hold per the resident until after rehabilitation. He wishes to for on his rehabilitation at this time. The DON will educate the nursing staff. How will the facility identify other resident.	tal cus e.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		155794	A. BUILDING		03/18/2013
			B. WING	CT ADDRESS CITY STATE ZID CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITY, STATE, ZIP CODE	
OTD ATE		T.I. C		GLEBE ST	
SIRAIF	ORD RETIREMEN	ILLC	CAR	MEL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	diagnoses that	included, but were not		having the potential to be	
	limited to, abdo	ominal aortic aneurysm		affected by the same practic	
		tervention and repair,		and what corrective action	
	_	ess, difficulty walking,		be taken? All residents have	
		n, hypertension,		potential to be affected by the	
		• •		alleged deficient practice. Al	
		history of spinal		active records have been aud and 4 residents have been	alleu
		nistory of epidural		identified to have internal car	diac
		ain control, and		devices. Four of the four	
	cardiomyopath	, ,		residents that were identifed	with
	infarction/AICD placement.			the internal cardiac devices h	nave
				been care planned according	
	The March, 2013 physician order			New admissions will be asse	ssed
	recap (recapitulation) sheet listed			within 24 hours of admission	and
		/13 for a daily INR		all current conditions will be	
		Normalized Ratioblood		assessed and care planned.	
	•			interim cardiac plan of care w	
	_	tory test), daily weight,		initiated within 24 hours by the admitting nurse for any interr	
	_	(blood pressure, pulse,		mechanical devices. An inte	
	temperature, re	espirations) every shift.		plan of care will be initiated w	
	There were no	orders for a routine		24 hours including a dental	
	(usually month	lly) check of the		assessment and referral if	
	defibrillator to I	be done with the		needed. What measures w	<u>rill</u>
	resident's card	iologist or other cardiac		be put into place to ensure	the_
	physician spec	•		practice does not recur?	
	priyoroidir opod	nanot.		Nursing staff will be educated	d on
	One Care Plan	entry dated 3/7/13		the assessment and care	
		n entry, dated 3/7/13,		planning procedures for all	Th
		roblem of at risk for		current resident diagnoses. DON or ADON will review all	
		culatory complications		admission nursing assessme	
	related to card	iac diagnoses. One		and care plans to ensure cur	
	approach listed	d was "Monitor heart		conditions are identified. Thi	
	sounds for abn	normal rhythm."		review will take place 5 days	
		-		week as part of her routine.	·
	There was no	Care Plan for AICD		will bring any identified issue	
	management.	23.2.1.3.7.102		the next scheduled morning	
	i management.			management interdisciplinary	<i>'</i>
	la an internet	0/45/40 -t 44:00		meeting for review and	
	in an interview	on 3/15/13 at 11:20		recommendations for follow-to-	ıp.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		URVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DBIG	00	COMPLE	ETED
		155794	A. BUIL			03/18/2	2013
			B. WING		ADDRESS SYMV STATE SIN CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
0.75 4.75	000 DETIDENT				LEBE ST		
STRAIF	ORD RETIREMENT	ILLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A.M., LPN #11	indicated she did not			How will the corrective action	<u>1</u>]	
	know what an	AICD was, did not			be monitored to ensure the		
		#26 had one, and did			deficient practice does not		
		precautions or care			recur and what QA will be pu		
		•			into place? The DON or ADC	N	
		or a person who had an			will bring the results of the		
	AICD device.				reviews to the monthly QA		
					Committee meeting for review		
					and recommendations. Any recommendation made by the		
					committee will be followed up		
					the DON or ADON and the res	,	
					will be brought to the next		
					scheduled QA Committee		
					meeting. This will continue on	an	
					ongoing basis.		
	2. The clinical	record for Resident					
	#27 was reviev	ved on 3/14/13 at 1:00					
	p.m.						
	•	uded, but were not					
	_	ession/anxiety,					
	•	-					
	• •	ropathy, borderline					
		ory issues, prostate					
	cancer and high	gh blood pressure.					
	The admission	assessment dated					
	3/2/13 for Resi	dent #27 indicated the					
		t have any oral issues					
	and he was on	•					
	CITA 110 WAO OII						
	Thoro wore se	notes regarding any					
		notes regarding any					
	proken teeth in	the assessment.					
	The resident's	clinical record had no					
	information reg	arding if Resident					
	_	ervices received from					
	the facility.						
	and radility.						

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Event ID: CR9N11

Facility ID: 011151

If continuation sheet Page 11 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155794	A. BUILDING	00	03/18/2013
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/10/2010
NAME OF I	PROVIDER OR SUPPLIE	₹		SLEBE ST	
STRATF	ORD RETIREMEN	TLLC		EL, IN 46032	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	There was an recapitulation of hours as need. The resident in teeth in his resident in an interview on 3/14/13 at 4 indicated she was resident had a She indicated from the physical the 28th and the she had seen in there was anythindicated there with a set of tee.	order on the physician's for Amoxicillin every 4 ed for dental work. Indicated he had broken sident interview on 30 a.m. I with the Social Worker 4: 35 p.m., she was not aware the my dental concerns. Ithere was an order cian who saw him on his was the first time it and did not know if thing going on. She was usually a form eth in a picture in some nat would indicate any			

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Event ID: CR9N11

Facility ID: 011151

If continuation sheet Page 12 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155794	A. BUII			03/18/	2013
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
0.75.4.75	ODD DETIDEMENT	-110			LEBE ST		
STRAIF	ORD RETIREMENT	LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
F000282	483.20(k)(3)(ii)						
SS=D		UALIFIED PERSONS/PER					
	CARE PLAN						
		vided or arranged by the					
		rovided by qualified					
		dance with each resident's					
	written plan of car						0.4/4.7/2.04.0
		view and record	F00	0282	What corrective action will b		04/17/2013
	review, the faci	lity failed to follow			taken by the facility? Reside		
	physician's ord	ers or the Care Plan			#7 has had no further episode		
	for 1 of 1 reside	ent who experienced a			retained soft stool in the rectur	n.	
		ne rectum that was			The staff will be counseled regarding the importance of		
	•	ed. (Resident #7)			following the Bowel and Bladd	or	
	digitally remove	ca. (Nesident#1)			protocol and physician orders		
	The allowance for all cod	1			resident #7. All nursing staff w		
	Findings includ	e:			be educated on the bowel and		
					bladder protocol and reporting		
	The clinical rec	ord for Resident #7			effectiveness of the treatment.		
	was reviewed of	on 3/15/13 on 10:00			MARS will be reviewed daily to)	
	A.M. The resid	lent was admitted on			ensure that staff is following		
	10/26/12 with c	liagnoses that			physician orders. All current		
		rere not limited to,			charts will be reviewed to ensu	ıre	
	· ·	entia with behaviors,			bowel function is being		
		,			documented and treated as		
	-	duodenal ulcer with			ordered. How will the facili		
	_	l bleeding, anemia,			identify other residents having		
	dysphagia (diff	iculty swallowing) with			the potential to be affected by	<u>v</u> _	
	weight loss/poo	or appetite,			the same practice and what	-2	
	hypertension, o	gastroesophageal			All residents have the potentia		
	• •	Stage 3 chronic kidney			be affected by the alleged	110	
	· ·	y of a coronary bypass			deficient practice. All current		
					charts will be reviewed to ensu	ıre	
	surgery, and co	ภาอแบลแบบ.			bowel function is being	-	
					documented and treated as		
		"Continence" on the			ordered. The MARS will be		
	"Admission Nu	rsing Evaluation" form,			reviewed for each resident to		
	dated 10/26/12	, indicated the resident			ensure that staff is following th	е	
		ent of bowels, had			physician orders pertaining to		
		nd used laxatives.			each resident. What measure		
	Jon Julipation, al	ia acca iaxatives.	1		will be put into place to ensu	re	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155794		LDING		03/18/	2013
			B. WIN		ADDRESS COMMUNICATE STR. CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					LEBE ST		
STRATE	ORD RETIREMENT	ILLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	There was no	other assessment			the practice does not recur?		
	information.				Evaluation of Bowel Assessme	ent	
					will be completed on new		
	The Quarterly MDS (Minimum Data				admissions, current residents,		
	•	•			significant change and quarter	ly	
	,	ent, completed on			thereafter. The C.N.A will		
	1/24/13, indica	ted the resident was			document Bowel Movements		
	severely impair	red in cognitive skills			Status on the ADL Tracking G		
	for making dail	y decisions, was totally			for all residents. A Nurse Bow		
	_	the physical assistance			Elimination Flow Sheet has be implemented to monitor bowel		
	•	rson for toileting, and			movements on a daily basis.		
	•	•			DON or ADON will audit each	IIIC	
		incontinent of her			resident record 5 days per wee	ek	
	bowels.				as part of her routine. She wil		
					bring any identified issues to the		
	The March, 20	13 physician order			next scheduled morning		
	recap (recapitu	ılation) sheet included			management interdisciplinary		
	orders for:	•			meeting for review and		
		olax (Bisacodyla stool			recommendations for follow-up).	
		. (milligrams) 1 tablet			How will the corrective action	<u>1</u>	
	, ,	,			be monitored to ensure the		
	every morning.				deficient practice does not		
		lax (Polyethylene			recur and what QA will be pu		
	Glycola laxati	ive) 17 Grams in 8			into place? The DON or ADC	νN	
	ounces of fluid	daily.			will bring the results of the		
	10/26/12MON	M (Milk of Magnesia) 30			reviews to the monthly QA		
	ml. (milliliters)	daily PRN (as needed).			Committee meeting for review and recommendations. Any		
	10/26/12Bisa	•			recommendation made by the		
		per rectum one time if			committee will be followed up	hv	
					the DON and the results will be	-	
	MOM not effec	tive.			brought to the next scheduled		
					Committee meeting. This will	~··	
	The November	r, 2012 MAR			continue on an ongoing basis.		
	(Medication Ac	Iministration Record)				ļ	
	indicated a sup	•				ļ	
	· ·	n 11/11/12 at 6:50				ļ	
	P.M. for "no BM in 3 days." A dose of					ļ	
		-					
		given on any day in				ļ	
	November Th	ere was no	1			l.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155794	B. WIN			03/18/2	013
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>		1	DDRESS, CITY, STATE, ZIP CODE		
0.7.0.4.7.5.4					LEBE ST		
STRATE	ORD RETIREMENT	LLC		CARME	L, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGHNOT		DATE
		in the previous dated 11/9, or the					
		te on 11/14/12 that					
		esident had stool					
	elimination pro						
	1	is given, or the results					
	from the suppo						
		onory.					
	A physician's n	rogress noted, dated					
		ted "A few days ago					
		rimacing, cryingwas					
		arge stool in rectum-					
		ally removed"					
	A Nurse's Note	es progress note, dated					
		P.M., indicated					
	"Resident alert	Grimacing and					
	crying. Large	stool noted in resident's					
	rectum. After p	placing resident on					
	stool/commode	e for awhile stool was					
	digitally remove	ed. Dulcolax					
	suppository us	ed. No results by end					
	of shift. Passe	d on to night nurse"					
		e, dated 2/11/13 at					
		licated "Resident has					
	BM [bowel mov	/ement] in rectum that					
		ligitally. XLG [extra					
	large] BM remo	oved. Resident					
		e relieved after stool					
		let day nurse know					
	about impactio	n to reassess."					
		0040 MAD: " 1					
	1	2013 MAR indicated					
		d not received any					
	MOM prior to the	ne digital removal of					

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Event ID: CR9N11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155794	A. BUILDING	00	COMPLETED 03/18/2013
		100184	B. WING	A PROPERTY OF THE PER	
NAME OF P	PROVIDER OR SUPPLIER			CADDRESS, CITY, STATE, ZIP CO GLEBE ST	DDE
STRATF	ORD RETIREMENT	TLLC		JLEBE 31 IEL, IN 46032	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	
TAG		dministration of the	TAG	BEFFERENCE	DATE
	suppository.	urininstration of the			
	On 3/15/13 at ⁻	11:45 A.M., the			
		sing provided a			
	policy/procedu				
	1	otocol." In an interview			
	at that time, the	e Director of Nursing			
	indicated that t	his was her written			
	policy which sh	ne had instituted in			
	October, 2012.				
	TI D II (D				
		cedure included, but			
		to, the following			
	information:				
	PROCEDURE	:.			
		ovements will be			
		facility medical record			
		aily by the licensed			
	nurse				
	8. Any residen	t not having a BM for 3			
	consecutive da	ys, will be given a			
	laxative or stoc	ol softener, as			
		he physician, at the			
		day. They will also be			
	offered high fib				
	_	ot contraindicated			
	medically				
		ot having results from			
		stool softener will			
		ository, if ordered by			
	the physician.				
	T	th afternoon, the			
	I resident still ha	is had no results, the			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155794	B. WIN			03/18/	2013
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			LEBE ST		
STRATE	ORD RETIREMENT	THC			EL, IN 46032		
	- CRD RETIREMEN						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	FERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	nurse will do a	n abdominal					
	assessment, c	hart the results of the					
	assessment ar	nd notify the MD for					
	further orders						
	Taransi Srasisiiii						
	The Director of	f Nursing indicated the					
		d a Policy/Procedure					
	1	noving stool, and					
		by on 3/15/13 at 11:45					
	l .	er was titled "Fecal					
		moval of" and was					
		on 11/1/12. The					
		ted "Digital removal of					
	1	n will be performed by a					
	licensed nurse	per physician order.					
	This procedure	e is contraindicated					
	after rectal or p	perineal surgery, in					
		have myocardial					
		nary inefficiency,					
		bolus, heart failure,					
	1 '	strointestinal or vaginal					
	_	_					
		orrhoids, rectal polyps,					
	or blood dyscra	asias"					
		n entry, dated 11/5/12,					
	addressed a pi						
	"Constipation."	' The "Interventions"					
		vere not limited to:					
	"Assess and de	ocument [resident's					
		ory of bowel habits					
	_	ation use, laxative use,					
		ercise, and personal					
	remedies.						
			\perp				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155794	A. BUI B. WIN	LDING		03/18/	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LEBE ST		
STRATE	ORD RETIREMENT	LLC		CARME	EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) cument [resident's	+	TAG	DLI ICENCI)		DATE
		I bowel movement					
	_	ng usual pattern, time					
	of day, amount	-					
	consistency of						
	-	sence of surgical					
		seases, and/or narcotic					
	use that may co	ontribute to					
	constipation.						
	Intervene with	laxative or stool					
	softeners as or						
	3.1-35(g)(2)						

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Event ID: CR9N11

Facility ID: 011151

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155794	B. WING		03/18/2013
	PROVIDER OR SUPPLIEI		2460 G	ADDRESS, CITY, STATE, ZIP CODE SLEBE ST EL, IN 46032	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000309 SS=D	HIGHEST WELL Each resident mount provide the services to attain practicable physically psychosocial well the comprehensicare. Based on interreview, the fact an effective beginner for 1 experienced a rectum that was sample of 1. (Findings included the comprehension of the clinical rectum that was reviewed A.M. The residual to the clinical rectum that was reviewed A.M. The residual to the clinical rectum that was reviewed to the clinical rectum	ust receive and the facility necessary care and or maintain the highest scal, mental, and III-being, in accordance with ve assessment and plan of exiew and record sility failed to implement owel management of 1 resident who large stool in the as digitally removed in a Resident #7) de: cord for Resident #7 on 3/15/13 on 10:00 dent was admitted on diagnoses that vere not limited to, nentia with behaviors, duodenal ulcer with al bleeding, anemia, ficulty swallowing) with or appetite, gastroesophageal, Stage 3 chronic kidney by of a coronary bypass	F000309	What corrective action will be taken by the facility? Resident #7 has had no further episodes of retained soft stool in the rectum. Staff will be educated on following the bowel and bladder protocol and reporting the effectiveness of the treatment. MARS will be reviewed daily to ensure that staff is following physician orders. All current charts will be reviewed to ensure bowel function is being documented and treated as ordered. Employees will be counseled regarding the bowel protocol. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All current charts will be reviewed to ensure bowel function being documented and treated as	<u>e</u>

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Event ID: CR9N11

Facility ID: 011151

If continuation sheet Page 19 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPL	ETED
		155794	A. BUIL B. WING			03/18/	2013
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF F	PROVIDER OR SUPPLIEF	R			LEBE ST		
STRATE	ORD RETIREMENT	THE			EL, IN 46032		
JIIAII	- CIND INCINICIN			CAINIL	L, IN 40032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		2, indicated the resident			ordered. The MARS will be		
	was not contin	ent of bowels, had			reviewed for every resident to		
	constipation, a	nd used laxatives.			ensure that staff is following the		
	There was no other assessment information.				physician orders pertaining to each		
					resident.		
					What measures will be put into		
	The Ouarterly	MDS (Minimum Data			place to ensure the practice does		
	1	ent, completed on			not recur?		
	1	•			not recur:		
	· ·	ted the resident was			Evaluation of Bowel Assessment will	I	
		red in cognitive skills			be completed on new admissions,		
		y decisions, was totally			current residents, significant change	9	
	dependent on	the physical assistance			and quarterly thereafter. The C.N.A		
	of one staff per	rson for toileting, and			will document Bowel Movements		
	was frequently	incontinent of her			Status on the ADL Tracking Grid for		
	bowels.				all residents. A Nurse Bowel		
					Elimination Flow Sheet has been		
	The March 20	13 physician order			implemented to monitor bowel		
		lation) sheet included			movements on a daily basis. The		
	orders for:	mation) sheet moladed			DON will audit each resident record		
		volay (Piagoodyl, a atool			5 days per week as part of her		
		colax (Bisacodyla stool			routine. She will bring any identified	d	
	, ,	. (milligrams) 1 tablet			issues to the next scheduled		
	every morning.				morning management		
		lax (Polyethylene			interdisciplinary meeting for review		
	Glycola laxat	ive) 17 Grams in 8			and recommendations for follow-up).	
	ounces of fluid	daily.			How will the corrective action be		
	10/26/12MON	M (Milk of Magnesia) 30			monitored to ensure the deficient		
	ml. (milliliters)	daily PRN (as needed).			practice does not recur and what		
	10/26/12Bisa	,			QA will be put into place?		
		per rectum one time if			<u> </u>		
	MOM not effect				The DON or ADON will bring the		
		eron 15 mg1/2 tablet			results of the reviews to the monthl	У	
		_			QA Committee meeting for review		
	for appetite stimulant, mechanical soft diet.				and recommendations. Any		
					recommendation made by the		
	· ·	ch Therapy for swallow			committee will be followed up by		
	function and co	ognitive communication			the DON and the results will be		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
ANDILAN	or connection	155794		LDING	00	03/18/	
		100704	B. WIN		DDDDGG GYMY GWARE GYR GODE	00/10/	2010
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LEBE ST		
STRATF	ORD RETIREMENT	LLC			EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	status as indica	ated.			brought to the next scheduled QA		
					Committee meeting. This will continue on an ongoing basis.		
	The November				Continue on an ongoing basis.		
	`	ministration Record)					
	indicated a sup	•					
		n 11/11/12 at 6:50					
	· ·	M in 3 days." A dose					
		ot given on any day in					
		Nurse's progress note,					
		, indicated "Resident is					
	_	chair while [family					
	-	with her. Resident					
		will follow objects with					
		s/symptoms of distress					
		lependent for all ADLs.					
		nack and ate all of it,					
	-	" There was no					
		in the previous					
	. •	dated 11/9, or the					
	•	te on 11/14/12 that					
		esident had stool					
	elimination pro						
		s given, or the results					
	from the suppo	isitui y.					
	The November	, 2012 "CNAADL					
		had documentation of					
	_	ay shift on 11/8/12.					
		as documented on					
	11/11/12 for the						
		ize and consistency of					
	each stool was	•					
		rogress noted, dated					
	2/13/13, indica	ted "A few days ago					

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Event ID: CR9N11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155794	A. BUIL	DING	00	COMPL: 03/18/	
		133734	B. WINC		PRESIDENCE CONTROL CON	03/10/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE LEBE ST		
STRATE	ORD RETIREMEN	TLLC			L, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		grimacing, cryingwas					
		large stool in rectum-					
	-had to be digi	tally removed"					
	A Nurse's Note	es progress note, dated					
		5 P.M., indicated					
		t. Grimacing and					
		stool noted in resident's					
	rectum. After	placing resident on					
	stool/commod	e for awhile stool was					
	digitally remov	red. Dulcolax					
		sed. No results by end					
		ed on to night nurse"					
		te, dated 2/11/13 at					
	•	dicated "Resident has					
	-	vement] in rectum that					
		digitally. XLG [extra					
		oved. Resident					
	1	e relieved after stool					
		let day nurse know on to reassess."					
		on to reassess.					
	The February	, 2013 "CNAADL					
	Tracking Form						
	_	n the resident had one					
	bowel movem	ent on 2/3 during the					
		one bowel movement					
	during the nigl	nt shift on 2/7, 2/8, and					
	2/9/13. Howe	ver, the size and					
	consistency of	each stool was not					
	identified.						
	The February	2013 MAR indicated					
	1	ad not received any					
		the digital removal of					

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Event ID: CR9N11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO.	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155794	B. WIN	G		03/18/	2013
NAME OF	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					LEBE ST		
STRATF	ORD RETIREMENT	TLLC		CARME	L, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dministration of the					
	suppository.						
	One Care Plan addressed a pr "Constipation." were listed as: document [resi history of bowe medication use fluids, exercise remedies; asse [resident's nammovement hist pattern, time of amount/frequestool. Assess frintervention, directly use that may constipation; er soften stool; infiname] on increpromote bowel with laxatives or or family to kee habits as need name] and famand non-pharm that may preve constipation."	The "Interventions" "Assess and dent's name] for all habits include at laxative use, diet, and personal ass and document are] for usual bowel ory, including usual af day, and personal assess, and/or narcotic contribute to a necourage fluids to the tervene with [resident's assed activity level to a function; intervene are stool softeners as a large [resident's name] are a diary of bowel and are a diary of bowel are a diary of bowel are a many of the silly on pharmocologic measures and or minimize and a minimize					
	were listed as: document [resi history of bowe medication use fluids, exercise remedies; asse [resident's nam movement hist pattern, time of amount/freque stool. Assess fi intervention, di use that may of constipation; et soften stool; int name] on incre promote bowel with laxatives of ordered; encou or family to kee habits as need name] and fam and non-pharm that may preve constipation." On 3/15/13 at a Director of Nur-	"Assess and dent's name] for el habits include e, laxative use, diet, a, and personal ess and document ne] for usual bowel ory, including usual f day, ncy, consistency of or presence of surgical seases, and/or narcotic ontribute to ncourage fluids to tervene with [resident's eased activity level to function; intervene or stool softeners as urage [resident's name] ep a diary of bowel ed; instruct [resident's nily on pharmocologic measures ent or minimize					

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Event ID: CR9N11

Facility ID: 011151

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155794	B. WING			03/18/	2013
		1	D. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			LEBE ST		
STRATE	ORD RETIREMEN	THE			EL, IN 46032		
							(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	Ι,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	``	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		otocol." In an interview		1710	<u> </u>		DATE
		e Director of Nursing					
	indicated that this was her written policy which she had instituted in October, 2012.						
	1	cedure included, but					
		I to, the following					
	information:						
	"DDGGEDUDE	_					
	"PROCEDURE						
		ent or responsible party					
	will be interview	•					
		essment about their					
		story, i.e. frequency of					
	BMs, time of d						
	4. CNAs will re	eport off to the charge					
	nurse at the er	nd of their shift if any of					
	their residents	have had a BM.					
	5. Bowel move	ements will be recorded					
	in the facility m	nedical record or					
	MAR/TAR dail	y by the licensed					
	nurse						
	8. Any resider	nt not having a BM for 3					
	consecutive da	ays, will be given a					
	laxative or stoo	•					
	prescribed by t	the physician, at the					
	l '	day. They will also be					
	offered high fib	-					
		ot contraindicated					
	medically	2.2.2					
		not having results from					
		stool softener will					
		ository, if ordered by					
		ository, ir ordered by					
	the physician.						1

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PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155794	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/18/2013		
	PROVIDER OR SUPPLIER ORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	10. If by the 4th afternoon, the resident still has had no results, the nurse will do an abdominal assessment, chart the results of the assessment and notify the MD for further orders The Director of Nursing indicated the facility also had a Policy/Procedure for digitally removing stool, and provided a copy on 3/15/13 at 11:45 A.M. The paper was titled "Fecal Impaction: Removal of" and was dated effective on 11/1/12. The "Policy" indicated "Digital removal of fecal impaction will be performed by a licensed nurse per physician order. This procedure is contraindicated after rectal or perineal surgery, in customers who have myocardial infarction, coronary inefficiency, pulmonary embolus, heart failure, heart block, gastrointestinal or vaginal bleeding, hemorrhoids, rectal polyps, or blood dyscrasias" 3.1-37(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155794	B. WIN			03/18/	2013
NAME OF B	AD CLUBED OD GUIDDUED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2460 GI	LEBE ST		
	ORD RETIREMENT	LLC			EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
F000329 SS=D	from unnecessary drug is any drug of dose (including descessive duration monitoring; or with for its use; or in the consequences which should be reduce combinations of the Based on a comparesident, the facily residents who has drugs are not given antipsychotic drug treat a specific condocumented in the residents who use receive gradual descent behavioral interverse.						
	record review, identify specific monitor for 1 or receiving antiperantide antidepressant sample of 10. Findings include Resident #7 was interview with a	medications in a (Resident #7)	F00	0329	What corrective action will be taken by the facility? Residen #7 clinical records will be reviewed with the family for history of need for the antipsychotic/antidepressant medication. These medication will be reviewed with the physician for the necessity of the medication and its continued need. Nursing staff will be educated regarding observation and documentation of signs, symptoms and side effects related to the use of these medications. How will the	nt ns he	04/17/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155794			03/18/2013
			B. WING	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R) GLEBE ST	
QTDATE/	ORD RETIREMEN	THE		MEL, IN 46032	
_		CAR			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	IATE CONTRIBUTION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
ı	was observed	at that time to be in a		facility identify other reside	<u>nts</u>
	Broda chair (a	specialized geri-chair).		having the potential to be	
	She would sm	ile at the family		affected by the same practi	
	member and s	troke his hand.		and what corrective action	
	Although she	would occasionally		<u>be taken?</u> All residents rece antipsychotic/antidepressant	<u> </u>
	1	vely with a nod of her		medication have the potentia	
	head for a "Ye	-		be affected by the alleged	
				deficient practice. All clinical	
	I = -	verbal responses to the		records will be audited and	
		vere garbled and		reviewed for diagnoses and	
	unintelligible.			signs/symptoms to support the	ne
				use of the	
	The clinical red	cord for Resident #7		antipsychotic/antidepressant	
	was reviewed	on 3/15/13 on 10:00		medication. What measure	
	A.M. Diagnos	es included, but were		will be put into place to ens	
		advanced dementia		the practice does not recur	<u>?</u>
	•	, depression, a		New diagnoses and new medications will be reviewed	
		•		daily. Resident/family intervi	
		r with gastrointestinal		and observation will occur w	
	bleeding, aner			72 hours of admission for	
	l ` •	lowing) with weight		supporting symptoms for	
	loss/poor appe	etite, hypertension,		diagnosis and use of medica	tion.
	gastroesophag	geal reflux disease,		All resident records will be	
	Stage 3 chroni	ic kidney disease,		audited and reviewed for	
	. •	ronary bypass surgery,		diagnoses and sign/sympton	ns to
	and constipation	, ,, , , , , , , , , , , , , , , , , ,		support the use of the	
		-		antipsychotic/antidepressant	
	The Admission	n MDS (Minimum Data		medication. This review will completed by the Social Service.	
		•		Director or DON 5 days per	
	l '	ent, dated 11/1/12,		as part of her routine. She w	
		esident had severe		bring any identified issues to	
		irment in daily decision		next scheduled morning	
		tle interest in activities,		management interdisciplinar	y
	had a poor app	petite, and did not have		meeting for review and	
	any psychosis	or behaviors. A		recommendations for follow-	•
	1	S assessment, dated		How will the corrective acti	
	1	ited the same with no		be monitored to ensure the	
	change.	aca are carrie with no		deficient practice does not	
	Glange.				[

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		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED
		155794	B. WIN			03/18/2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
OTD ATE		-110		1	LEBE ST	
	ORD RETIREMENT				EL, IN 46032	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	` `	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG		DATE
	The admission Sheet," dated that included: Quetiapine (Se antipsychotic m (milligrams), M an antidepress ("for weight los Sertraline (Zolo medication) 10 Subsequent phincluded: 10/28/12Decrepo (by mouth) of 11/1/12Add disorder 11/5/12Decreto 7.5 mg. 12/5/12Decreto 7.5 mg. 20/5/12Decreto 7.5 mg. 20/5/12Decre	"Medication Transfer 10/26/12, listed orders 10/26/19/19/19/19/19/19/19/19/19/19/19/19/19/			recur and what QA will be puinto place? The Social Service Director or DON will bring the results of the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up the Social Service Director and the results will be brought to the next scheduled QA Committee meeting. This will continue or ongoing basis.	by dene
	"Depression," v	with no other ne specific manner in				

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		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155794	B. WING		03/18/2013
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	DE
STRATE	ORD RETIREMEN	THC		GLEBE ST EL, IN 46032	
				LL, IN 40002	T
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	
		dent displayed			
		was not identified.			
	The Decembe	r, 2012			
	"Behavior/Inte	rvention Monthly Flow			
	Record" sheet	for the Quetiapine			
	medication ha	d no behaviors listed,			
	and the page	was blank.			
	l				
	The February,				
	"Behavior/Intervention Monthly Flow Record" sheet listed medications of Zoloft, Remeron, and Seroquel. The				
	•	ted on the sheet were			
		ood," and "sad facials."			
	Change in the	JOU, and Sauraciais.			
	In an interview	on 3/15/13 at 2:50			
		ctor of Nursing			
	· ·	Social Service Director			
		ehavior monitoring			
		er reviewing the			
	"Behavior Flow	w Record" sheets, she			
	indicated the i	nformation listed in the			
	"Behavior" sed	ction should be more			
	descriptive an	d specific in order to			
		ne resident displayed			
	behaviors.				
	la sa tri	0/45/40 -1.0.40			
		on 3/15/13 at 3:40			
	· '	al Service Director			
		Behavior/Intervention"			
		rom the facility the names of the			
		sted at the bottom. She			
		added the "behavior" in			

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	of correction identification number: 155794	(X2) MULTIPLE CON A. BUILDING B. WING	00	COMPI 03/18		
	PROVIDER OR SUPPLIER ORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	the box, and any diagnosis needed, if not listed. She indicated some residents do not have any symptoms of behavior.					
	3.1-48(a)(3)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	TE SURVEY MPLETED	
		155794	B. WING			18/2013
	ROVIDER OR SUPPLIER		2460 G	ADDRESS, CITY, STATE, ZIP LEBE ST EL, IN 46032	CODE	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETION
	`			CROSS-REFERENCED TO THE		
		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)		DATE
TAG F000334 SS=E	483.25(n) INFLUENZA AND IMMUNIZATIONS The facility must of procedures that eteroid (i) Before offering immunization, ear resident's legal resident's legal resident's legal residential side effects of influenzation oct annually, unless the medically contrain already been immunization oct annually, unless the medically contrain already been immunization; and (iv) The resident of representative has immunization; and (iv) The resident's documentation that the following: (A) That the residentes representative was regarding the beneffects of influenze influenza immunization; and (B) That the residentes and the resident	Develop policies and insure that the influenza ich resident, or the impresentative receives ing the benefits and icts of the immunization; is offered an influenza ober 1 through March 31 he immunization is indicated or the resident has indicated or the resident has indicated during this time in the resident's legal is the opportunity to refuse it indicates, at a minimum, it is provided education in indicates, at a minimum, it is provided education in indicates, at a minimum, it is provided education in indicates, and indicates in	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	The facility must of procedures that ending in the control of the	develop policies and insure that the pneumococcal ch resident, or the inpresentative receives and the benefits and incite of the immunization; is offered a pneumococcal less the immunization is indicated or the resident has				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155794	B. WING		03/18/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L			
OTD ATE				SLEBE ST	
STRAIF	ORD RETIREMENT	LLC	CARIVII	EL, IN 46032	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	(iii) The resident of	or the resident's legal			
	•	is the opportunity to refuse			
	immunization; an				
	` '	s medical record includes			
		at indicated, at a minimum,			
	the following:	idant an masidantla land			
		ident or resident's legal as provided education			
	•	nefits and potential side			
		ococcal immunization; and			
	•	ident either received the			
	, ,	munization or did not			
		nococcal immunization due			
	to medical contra	indication or refusal.			
	(v) As an alternat	ive, based on an			
	assessment and	•			
		, a second pneumococcal			
		y be given after 5 years			
	following the first				
	immunization, un	r the resident or the			
		epresentative refuses the			
	second immuniza				
	Based on reco		F000334		04/17/2013
			1 000334	What corrective action will be	04/17/2013
		acility failed to ensure		taken by the facility?	
	•	ccal vaccine was		tanen by the facility:	
		5 residents reviewed		Residents #1 and #13 received their	
	for documentat	tion and education		immunizations from their private	
	regarding influe	enza and		physicians within the appropriate	
	pneumococcal	vaccinations.		timeframes. Documentation	
	(Resident #1 a	nd Resident # 13)		pertaining to the immunizations wil	ı [
		,		be transcribed in their clinical record	
	Findings includ	le:		on the immunization form. All	
				records will be audited to ensure	
	1. The record r	eview for Resident #1		that the influenza and	
		on 3/13/13 at 2:00		pneumococcal vaccinations have	
	•			been given and documented on the	
	•	s included, but were		immunization record along with the	
		ascular dementia with		signed consents.	
	depression, lar	ge ischemic right sided			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ETED
		155794	B. WIN			03/18/2	2013
			э. W II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	8			LEBE ST		
STRATE	ORD RETIREMENT	THC			EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORR			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
	stroke, paroxysmal afib (affibrillation),				How will the facility identify other		
		hrectomy , pituitary			residents having the potential to be	<u> </u>	
	tumor excision	(9/98), chronic renal			affected by the same practice and		
	insufficiency, ri	ght bundle branch			what corrective action will be taken?		
	block, depress	ion, high blood			<u>takenr</u>		
	pressure, and	hypercholesterolemia.			All residents have the potential to b	e	
	, , , , , , , , , , , , , , , , , , ,				affected by the alleged deficient	-	
	The document	ation for the influenza			practice. Immunization		
		occal vaccination were			documentation pertaining to		
	•				influenza and pneumococcal		
	reviewed. The flu vaccination				vaccinations will be obtained on		
	indicated no vaccination was desired.				admission and annually thereafter.		
	The information had no date and no				Signed consents to administer the		
	_	the resident, resident			vaccinations will be obtained from		
	representative,	or a power of attorney			the resident or responsible party.		
	or healthcare c	lesignee. The					
	pneumococcal	vaccination had no			What measures will be put into		
	signatures or d	lates noted and nothing			place to ensure the practice does		
	marked as to w	whether the resident did			not recur?		
	or did not want	the pneumococcal			New admissions will be audited		
	vaccination.	•			utilizing the new admission chart		
					review to ensure that consents or		
	2 The record	review for Resident			declinations have been signed. The		
		leted on 3/14/13 at			clinical documentation for new		
					admissions will be audited within 72	<u> </u>	
	_	noses included, but			hours of admission. All new		
		d to, history of failure to			admissions will be audited 5 days		
	_	ition, hyponatremia,			per week by the DON or ADON as		
	lung cancer, ur	rinary tract infection,			part of her routine. Current residen	t	
	chronic obstruc	ctive pulmonary			records will be monitored quarterly		
	disease, chron	ic back pain with			with their individual care plans.		
	history of comp	oression fractures,			The DON or ADON will bring any		
		nary incontinence,			identified issues to the next		
	•	requency hearing loss,			scheduled morning management		
	_	s with anorexia.			interdisciplinary meeting for review		
	and weight los	o with difficald.			and recommendations for follow-up		
	The ale	ation for the inflation					
	i ne aocument	ation for the influenza			How will the corrective action be		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	OING	00	COMPLETED	
		155794	B. WING			03/18/2013	
		1		_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	3			LEBE ST		
	ORD RETIREMEN	TLLC			EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	•	X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	LETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DA	TE
	and pneumoco	occal vaccination were			monitored to ensure the deficient		
	reviewed. The	pneumococcal			practice does not recur and what		
	vaccination ha	d nothing marked as to			QA will be put into place?		
		sident did or did not			TI DOM 17501 1711 1		
	want the pneu	mococcal vaccination.			The DON or ADON will bring the		
		documentation if this			results of the reviews to the month	У	
		cated for this resident.			QA Committee meeting for review and recommendations. Any		
		date and no signature			recommendation made by the		
		_			committee will be followed up by		
	from the reside	•			the DON and the results will be		
	· ·	, or a power of attorney			brought to the next scheduled QA		
	or healthcare of	designee.			Committee meeting. This will		
					continue on an ongoing basis.		
		with the Director of					
	Nursing (DON)) on 3/15/13 at 2:00					
	p.m., she indi	cated the informed					
	consent for flu	and pneumococcal					
	vaccine should	be signed and a					
		nating whether they					
		nation or not should be					
	documented.	nadon or not onedia se					
	accumented.						
	A request was	made of the DON for					
	•	made of the DON for					
		mmunizations of					
		l and Influenza for					
	residents on 3	/13/13 at 11 A.M.					
		led "Immunizations:					
	Influenza (flu)						
	Residents, Sta	ff, and Volunteers"					
	dated 2012, was provided by DON on						
	3/13/13 at 1:00	p.m. The document					
		signed consent is					
		ding to state law, it					
	1	this procedural step.)					
	D. Residents, staff and volunteers						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155794	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 03/18	LETED
	PROVIDER OR SUPPLIER ORD RETIREMENT LLC	2460 G	ADDRESS, CITY, STATE, ZIP (LEBE ST EL, IN 46032	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	may refuse vaccination. Vaccination refusal and reasons whyshould be documented by the facility" There was no specific documentation in the policy regarding documentation of acceptance or refusal of the pneumococcal vaccine, or of contraindications to the vaccination. 3.1-13(a)				

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Event ID: CR9N11

Facility ID: 011151

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155794	A. BUIL B. WING			03/18/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LEBE ST		
QTDATE(ORD RETIREMENT	-110			EL, IN 46032		
SIRAIF	JRD RETIREWENT	LLC		CARIVIE	EL, IN 40032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000425 SS=D	483.60(a),(b) PHARMACEUTIC PROCEDURES, The facility must personnel to admorphism permits, but only supervision of a li A facility must proservices (includin the accurate acquestispensing, and a and biologicals) to resident. The facility must proservices of a licer provides consultate provision of pharm Based on observed review, ensure a routin available and a resident observed pass, until the postained by the own pharmacy Findings included On 3/14/13 at 9 was observed to the accurate acquestion of th	CAL SVC - ACCURATE RPH provide routine and and biologicals to its in them under an ibed in §483.75(h) of this may permit unlicensed inister drugs if State law under the general idensed nurse. Divide pharmaceutical g procedures that assure uiring, receiving, administering of all drugs of meet the needs of each employ or obtain the needs of harmacist who atton on all aspects of the macy services in the facility. Envation, interview and the facility failed to be medication was administered to 1 of 1 and during medication medication could be a family through their (Resident #13) Dec. 2:30 A.M., LPN #11	F00	0425	What corrective action will be taken by the facility? The medication for resident #13 has been delivered to the facility are is being dispensed per physiciorder. A policy and procedure regarding the timely filling of prescriptions supplied by an outside vendor has been implemented. The MARS will audited by nursing staff to ensithat all current ordered medications are in stock and a being dispensed per physician order. Nursing staff will be educated regarding the timely	s nd an be ure	DATE 04/17/2013
					filling of prescriptions supplied	•	
		ent received seven			an outside vendor. How will t		
	pills.				facility identify other resident	ts_	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPLETED
		155794	A. BUIL			03/18/2013
		1	B. WINC			
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	
					LEBE ST	
STRATF	ORD RETIREMEN	TLLC		CARME	EL, IN 46032	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					having the potential to be	
	Upon reconcili	ation with the			affected by the same practic	<u>e</u>
					and what corrective action w	<u>rill</u>
	physician's orders, it was determined that a Tab-A-Vite vitamin pill, scheduled to be given with the morning medications, had not been				be taken? All residents have	the
					potential to be affected by the	
					alleged deficient practice. A	
					policy and procedure regardin	g
	given. The ord	der was dated 8/31/12			the timely filling of prescription	
	•	one tablet by mouth			supplied by outside vendor ha	S
		one tablet by mean			been implemented along with	
	The MAR (Medication Administration Record) was reviewed on 3/14/13 at				nurse education. What	
					measures will be put into pla	<u>ice</u>
					to ensure the practice does i	
					recur? All MARS will be audi	
	1:11 P.M Do	ses of the vitamin were			by nursing staff to ensure that	
		, 3/12, 3/13, 3/14/13,			current ordered medications a	
		medication had not			in stock and are being dispens	
	-				per physician order. All reside	
		he "Nurse's Medication			MARS will be audited 5 days	
	Notes" on the	reverse side of MAR			week by the DON as part of h	er
	sheet indicated	d "pharm [pharmacy]			routine for 3 months and a	
	notified" on 3/1	11/13, and "awaiting			pattern of compliance has bee	
		aiting arrival" on 3/13			established. She will bring an identified issues to the next	У
		hing was marked for			scheduled morning managem	ont
		Tillig was marked for			interdisciplinary meeting for	CIIL
	3/12/13.				review and recommendations	for
					follow-up. How will the	
	In an interview	on 3/15/13 at 9:20			corrective action be monitor	ed
	A.M., LPN #11	indicated the family			to ensure the deficient pract	
	"provided" the	medications, meaning			does not recur and what QA	
	l .	had prescriptions filled			will be put into place? The	
	1	cy of the resident's			DON or ADON will bring the	
		-			results of the reviews to the	
		uld bring in to the			monthly QA Committee meeti	ng
	facility.				for review and	=
					recommendations. Any	
	On 3/15/13 at	2:25 P.M., a copy of			recommendation made by the	
		t was provided. The			committee will be followed up	by
		dication was not			the DON and the results will b	e
					brought to the next scheduled	QA
	administered of	administered on 3/15/13, and the				

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 OF CORRECTION	IDENTIFICATION NUMBER: 155794	A. BUII	LDING	00	COMPLETED 03/18/2013	
ROVIDER OR SUPPLIER ORD RETIREMENT			STREET A	ADDRESS, CITY, STATE, ZIP CODE LEBE ST EL. IN 46032		
SUMMARY ST (EACH DEFICIENCE REGULATORY OR note on the rev "awaiting arriva" In an interview P.M., the Direct indicated she w she had a Police was only comm medications fro pharmacy until provide them. In an interview P.M., the Direct indicated she d Policy/Procedu medications fro pharmacy while	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) erse side indicated al." on 3/15/13 at 2:25 tor of Nursing yould have to see if cy/Procedure, but it non sense to get om the facility the family could on 3/18/13 at 4:45 tor of Nursing id not have any re for obtaining om the facility e waiting for es to receive from their	B. WIN	STREET A		RS e thly	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155794	A. BUII B. WIN			03/18/	2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
OTDATE	ODD DETIDEMENT				LEBE ST		
STRAIF	ORD RETIREMENT	LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F009999							
	STATE FINDIN	IGS	F00	9999	What corrective action will b	e l	04/17/2013
					taken by the facility? C.N.A.		
	3.1-14 PERSC	NNEL			12, C.N.A.#13, C.N.A.#15 and		
	3.1-14 1 LINOC	MINEL			C.N.A.#16 will have specific jo		
					orientations and physical		
	` ''	cility shall maintain			examinations completed by		
	current and acc	curate personnel			4/17/13. C.N.A # 15, C.N.A#1		
	records for all e	employees. The			C.N.A. #13 and Server #17 wil		
	personnel reco	rds for all employees			have the tuberculin skin test or		
	•	e following: (7)			positive, the tuberculosis scree		
	Documentation of orientation to the				by 4/17/13. How will the facil		
	facility and to the specific job skills.				identify other residents havin		
	lacility and to ti	ie specific job skilis.			the potential to be affected b	<u>v</u>	
					the same practice and what		
	This State rule	was not met as			corrective action will be take		
	evidenced by:				All employee files will be audit	ea	
					for information pertaining to specific job orientations, PPD		
	Based on interv	view and record			documentation and physical		
	review the faci	lity failed to ensure 4			examinations. Any employee		
		reviewed, who were			identified as lacking this		
					information will receive the		
		last annual survey on			appropriate assessments and		
	· ·	eived orientation to			specific job orientations by		
	their specific jo	b skills. (CNA #12,			4/17/13. What measures will	<u>be</u>	
	#13, #15 and #	16)			put into place to ensure the		
					practice does not recur? All		
	Findings includ	e·			new hires will complete the job		
	i mamigo moraa	.			specific job orientations during		
	The records for	r 4 ampleyage bired			their orientation period. The		
		4 employees hired			tuberculin skin test		
		nnual survey on 1/4/12			documentation or if positive, th		
	were selected f				tuberculosis screen and physic		
	Documentation	for specific job			examinations will be completed	u	
	orientation was	not found for:			prior to their first day of work. The tuberculin skin test or if		
					positive, the tuberculosis scree	_{an}	
	CNA #12hire	date 8/24/12			will be completed on an annua		
					basis for each employee. The		
	CNA #13hire	uale 9///12			Business Office Manager will		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
		155794	A. BUI B. WIN			03/18/2013	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LEBE ST		
OTD ATE		-110					
SIRAIF	ORD RETIREMENT	LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	CNA #15hire	date 12/8/12			maintain the Employee Record	t	
	CNA #16hire	date 12/7/12			checklist to ensure that all		
					documentation is timely. The		
	In an interview	on 3/18/13 at 4:00			employee files will be audited		
		ness Office Manager,			a monthly basis by the Busine		
		_			Office Manager. She will bring any identified issues to the nex		
	who was respo				scheduled morning manageme		
		f the personnel files,			interdisciplinary meeting for		
		of the forms in the file			review and recommendations	for	
	was for orienta	tion to job skills. After			follow-up. How will the		
	reviewing the fo	orm, she indicated it			corrective action be monitore	<u>ed</u>	
	was very similar to the one for general orientation, and did not address				to ensure the deficient practi	<u>ce</u>	
					does not recur and what QA		
	· ·	ills required for a CNA.			will be put into place? The		
		and required for a Grati.			Business Office Manager or		
	O (4) A rahaasia	al acception ation along the			Administrator will bring the res		
	\ , ,	al examination shall be			of the reviews to the monthly (
	-	ch employee of a			Committee meeting for review		
		ne (1) month prior to			and recommendations. Any recommendation made by the		
	employment.				committee will be followed up	hv	
					the Business Office Manager a		
	This State rule	was not met as			the results will be brought to the		
	evidenced by:				next scheduled QA Committee		
					meeting. This will continue on	an	
	Rased on inter	view and record			ongoing basis.		
	•	ility failed to obtain a					
		nation, completed by					
	Physician, Nurs						
	Physician's Ass	sistant, or Certified					
	Nurse Specialis	st, for 4 of 4 employees					
	reviewed, who	were hired since the					
		vey on 1/4/12. (CNA					
	#12, #13, #15,	,					
	, , , <u>, , , , , , , , , , , , , , , , </u>	ana 11 10)					
	Eindings includ	lo:					
	Findings includ	E.					
	The records for	r 4 employees hired					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155794		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/18/2013	
	PROVIDER OR SUPPLIE		STREET A 2460 G	ADDRESS, CITY, STATE, ZIP CODE LEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
	were selected Documentation examination co				
	Assessment" s by a facility RN CNA #13hire	ed 9/7/12. A "Health screen was completed N on 10/20/12. ed 12/8/12			
	P.M., the Exec that CNA #12 rotated in and skilled unit, wo	on 3/18/13 at 3:15 cutive Director indicated and CNA #13 were out of the certified orking at other times on esidential unit.			
	be required for facility within or employment, or prior to employ annually there nonpaid persor be screened for health care wo a documented	resical examination shall reach employee of a one (1) month prior to (1) At the time of or within one (1) month yment, and at least after, employees and nnel of facilities shall or tuberculosis. For orkers who have not had negative tuberculin during the preceding			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	I DINC	00	COMPL	ETED
		155794	A. BUI. B. WIN	LDING IG		03/18/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			LEBE ST		
STRATE	ORD RETIREMEN	THE			EL, IN 46032		
JIIAII		I LLC		CAINIL			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	twelve (12) mo	onths, the baseline					
	tuberculin skin	testing should employ					
	the two-step m	nethod. If the first step					
	is negative, a s	second test should be					
	_	(1) to three (3) weeks					
	after the first s	• • •					
	This State rule was not met as						
		was not met as					
	evidenced by:						
	Based on interview and record review, the facility failed to obtain a first and second step tuberculin skin						
	test for 2 of 2 e	employees hired since					
	the last survey	on 1/4/12; failed to					
	obtain an annu	ual tuberculin skin test					
		oyee, and failed to do					
	•	erculosis screen for 1 of					
		no had a previous					
		-					
	•	on. (CNA #15, CNA					
	#16, CNA #14,	, and Server #17)					
	Findings include	de:					
	The records fo	r 4 employees hired					
	since the last a	annual survey on 1/4/12					
		for review. The					
		mployees hired prior to					
		were also selected for					
	_	mentation of tuberculin					
	_	annual tuberculosis					
	screening was	not found for:					
		d 12/8/12, no first or					
	second step tu	berculin testing prior					

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Facility ID: 011151

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	OF CORRECTION OF CORRECTION 155794	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/18/2013	
	PROVIDER OR SUPPLIER ORD RETIREMENT LLC	2460 GI	ADDRESS, CITY, STATE, ZIP COE LEBE ST EL, IN 46032	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	COMPLETION	Ν
	to, or at, hire. There was no documentation of a previous negative test in the preceding 12 months. CNA #16hired 12/7/12, no first or second step tuberculin testing prior to, or at, hire. There was no documentation of a previous negative test in the preceding 12 months. CNA #14the employee was identified as having a previous positive tuberculin skin test. The last tuberculosis screen was dated 9/26/11. Server #17the employee was identified as having a previous positive tuberculin skin test. No previous tuberculosis screen was found, and no current screen was found, and no current screen was found. In an interview on 3/18/13 at 4:00 P.M., the Business Office Manager, who was responsible for the maintenance of the personnel files, indicated she was unable to locate any of the tests or screens. 3.1-14(q)(7) 3.1-14(t) 3.1-14(t)(1)				

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Event ID: CR9N11

Facility ID: 011151

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPL	ETED
		155794	A. BUII			03/18/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
0.75 4.75	ODD DETIDEMENT				LEBE ST		
STRAIF	ORD RETIREMENT	LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΤE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE	
R000214	410 IAC 16.2-5-2	(a)				•	
	Evaluation - Defic	ciency					
	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident 's condition, or more often at the resident 's or facility 's request. A licensed nurse shall evaluate the nursing						
	needs of the resid						
	Based on reco		R000214		What corrective action will be		04/17/2013
			KU	10214	taken by the facility? As of	<u>be</u>	04/1//2013
		acility failed to ensure			November, 2012, a policy and		
	•	issessments were			procedure regarding		
	completed for 2	2 of 5 residents			pre-admission has been		
	reviewed for pr	eadmission			implemented by Senior Living		
	assessments. (Resident #29 and			Communities. Prior to admiss	ion,	
	#31)	•			this assessment will be	,	
					performed by a licensed nurse	to	
	Eindings includ	0.			determine appropriate level of		
	Findings includ	e.			care and approximate services	3	
					being required. This information	on	
		ecord was reviewed			is based on interviews from		
	for Resident # :	29 on 3/18/13 at 9:15			resident and resident family		
	a.m. Diagnoses	s included, but were			members. All resident records		
	not limited to, h	nigh blood pressure,			will be reviewed for pre-admissing health assessments. Prior to	sion	
	osteoarthritis, o				admission, the designee will		
		ancer and breast			ensure that all admission		
	cancer.	ander and breast			paperwork is completed and		
	Caricer.				placed in the active clinical		
					record. How will the facility		
	The clinical rec				identify other residents havir	<u>ıg</u>	
	assessments p	rior to Resident #29			the potential to be affected b	<u>y</u>	
	admission date	on 10/5/12 regarding			the same practice and what		
	residents healt	h status.			corrective action will be take	<u>n?</u>	
					All residents have the potentia	I to	
					be affected by the alleged		
					deficient practice. The		
					interdisciplinary team will be		
					educated regarding the		
					pre-admission assessment		

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 44 of 56

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155794	A. BUILDING B. WING	00	COMPLETED 03/18/2013		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
STRATF	ORD RETIREMENT	LLC	2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				protocol. All resident records to be audited to determine that the are appropriate for their current level of care and for documentation pertaining to the pre-admission health status assessment. What measures will be put into place to ensure the practice does not recur? During the evaluation stage proto admission, the interdisciplinate team will meet to discuss residenceds and potential level of care. The interdisciplinary team will review all pre-admission assessments and health status assessments to ascertain resident needs and determine appropriate level of care. The admission will be dependent unthe completion of the pre-admission assessment. The pre-admission assessment will reviewed prior to resident admission. The ADON will audie each new admission resident record as part of her routine. Will bring any identified issues the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be pure into place? The ADON or designee will bring the results the reviews to the monthly QA Committee meeting for review and recommendations. Any	ney int ine		

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 45 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
		155794	B. WING		03/18/2013
	ROVIDER OR SUPPLIER		2460 G	ADDRESS, CITY, STATE, ZIP CODE SLEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	2. The clinical r	ecord for Resident #31 3/18/13 at 11:20 A.M.		recommendation made by the committee will be followed up the ADON or designee and the results will be brought to the n scheduled QA Committee meeting. This will continue on ongoing basis.	by e ext
	with diagnoses the limited to, histor	s admitted on 6/18/12 hat included, but were not y of a fractured hip, failure, atrial fibrillation,			
	history of rectal colectomy, pulm	cancer with a distal conary nodule, depression, ation, and osteoporosis.			
	A pre-admission resident's needs	evaluation of the was not found.			
	the Assistant Dir indicated she had with the corporat the corporate off pre-admission ev until late Decem date, pre-admiss done in their con	d discussed this issue te office. According to ice, a system to do a valuation was not in place ber, 2012. After that ion evaluations were inputer system. She			
	was completed of admission to the as the "pre-admi indicated she had	uation of the resident that on the date of her facility, and identified it ssion" evaluation. She d no other evaluation of r to her admission on			

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 46 of 56

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COM	E SURVEY PLETED
		155794	B. WING		_	8/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP LEBE ST	CODE	
STRATF	ORD RETIREMENT	LLC		EL, IN 46032		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LIGHT DESCRIPTION OF DEFICIENCY ATTOMORY.	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR 6/18/12.	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	G, 16, 12.					

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 47 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JETIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155794	B. WIN	G		03/18/	2013
NAME OF P	ROVIDER OR SUPPLIER		•	STREET .	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOI I EIEK			2460 G	LEBE ST		
STRATF	ORD RETIREMENT	LLC		CARM	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000349	410 IAC 16.2-5-8	* * * * *					
	Clinical Records -						
		ust maintain clinical records					
		These records must be the supervision of an					
		acility designated with that					
		e records must be as					
	follows: (1) Complete. (2) Accurately documented.						
(3) Readily accessible.							
	(4) Systematically organized. Based on record review and		DOG	0240			04/17/2012
			RUC	00349	What corrective action will be		04/17/2013
	interview, the facility failed to ensure				taken by the facility? Reside #33 and #34 have been	nι	
		plete and thorough			discharged. The nursing staff	will	
		for 3 of 7 residents			be educated regarding proper		
	reviewed for do			documentation standards for			
	(Resident #33	and #34).			residential residents; the use of	of	
					the SBAR Format for unusual		
	Findings includ	e:			occurrences; the use of the accident investigation tool; and	٠,	
					drug disposition. How will the		
	1. The closed	clinical record for			facility identify other residen	_	
	Resident #33 v	vas reviewed on			having the potential to be		
	3/18/13 at 10:3	0 a.m. Diagnoses			affected by the same practice	_	
	included, but w	ere not limited to, atrial			and what corrective action w	_	
	fibrillation, cong	gestive heart failure,			be taken? All residents have	the	
	low vision, and	enlarged prostate.			potential to be affected by the alleged deficient practice. The	_	
					nursing staff will be educated	,	
	The nurses not	es for 1/8/13 at 6:00			regarding proper documentation	on	
		, " Res [resident]			standards for residential		
		at he fell. Res states 'I			residents; the use of the SBAF		
		irn around in the			Format for unusual occurrence	es;	
		nd] my legs gave			the use of the accident		
	_	ified. MD returned			investigation tool; and drug disposition. What measures v	will	
	•	was no indication of			be put into place to ensure the		
					practice does not recur? The		
	_	g taken anywhere in			resident records will be monitor		
	the clinical reco	ora.			to ensure that nursing		

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 48 of 56

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155794	B. WING		03/18/2013	
NAME OF D	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	•	2460 G	SLEBE ST		
	ORD RETIREMENT			EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	•	DATE	
TAG	The nursing not indicated, "10 leaving [sign for care then to so was explanation resident was becare. No prior indicated any or resident health 2. The clinical was completed a.m. Diagnoses not limited to, A depression, an obstructive pull. The nurses not indicated, "ha [medication-rel daughter to sign the medication daughter refusion over to D.O.N The note did not done with med In an interview Nursing on 3/1 indicated they indicated they in the sign of the medicated they indicated the	record for Resident #34 I on 3/18/13 at 11:00 Is included, but were Alzheimer's with xiety and chronic monary disease. Ites for 2/12/13 at p.m., ad drug disposition ease forms] for In [sign for with] all of the facility had for res ted to sign turn issue" In the dictate what was ications. with the Director of 8/13 at 1:30 p.m., she did not have any	TAG	documentation and adequate follow-up is completed for cha of condition and drug dispositi. The ADON or designee will review the records 5 days per week as part of her routine. Swill bring any identified issues the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be purinto place? The ADON or designee will bring the results the reviews to the monthly QA Committee meeting for review and recommendations. Any recommendation made by the committee will be followed up the ADON or designee and the results will be brought to the not scheduled QA Committee meeting. This will continue or ongoing basis.	nge on. che to p. n by e ext	
	documentation	ne drugs other than				
		e nursing notes.				
		<u> </u>				

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PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155794	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP. 03/18	
NAME OF P	ROVIDER OR SUPPLIER			.DDRESS, CITY, STATE, ZIP C _EBE ST	CODE	
STRATF	ORD RETIREMENT	LLC		L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 50 of 56

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155794	B. WING		03/18/2013	
			_	EET ADDRESS, CITY, STATE, ZIP COI	DE .	
NAME OF PR	ROVIDER OR SUPPLIER			60 GLEBE ST		
STRATEC	RD RETIREMENT	TIIC		RMEL, IN 46032		
				14002		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE APP	PROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAC	DEFICIENCY)	DATE	
R000354	410 IAC 16.2-5-8					
	Clinical Records	•				
	following:	n shall include the				
	(1) Identification (lata				
	` '	ransferring institution.				
		eceiving institution and				
	date of transfer.	C				
	(4) Resident 's pe	ersonal property when				
	transferred to an					
	` '	s relating to the resident '				
	S:	***				
	(A) functional abil limitations:	ities and physical				
	(B) nursing care;					
	(C) medications;					
	(D) treatment; and	d				
	• •	nd condition on transfer.				
	(6) Diagnosis.					
	(7) Date of chest	x-ray and skin test for				
ļ	tuberculosis.					
	Based on recor	rd review and	R000354		04/17/2013	
	interview, the fa	acility failed to have		What corrective action will b	<u>oe</u>	
	complete docu	mentation relating to		taken by the facility?		
	the transfer/dis	charge from the facility				
		d records reviewed for		Resident #33 and #34 have be		
		entation. (Resident		discharged. The nursing staff		
	#33 and #34)	(educated on the documentat		
	1100 and #07)			requirements of the discharg	e	
	Findings includ	Φ.		summary and transfer form.		
	i ilialingo iliolaa	C .		How will the facility identify	other	
	1 The closed of	clinical record for		residents having the potentia		
		vas reviewed on		affected by the same practic		
				what corrective action will be		
		0 a.m. Diagnoses		taken?		
	· ·	ere not limited to atrial				
		gestive heart failure,		All residents have the potent	ial to be	
	low vision, and	enlarged prostate.		affected by the alleged defici	ent	
				practice. The nursing staff wi	ill be	
I		"Discharge	1	educated on the documentat		

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 51 of 56

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	ETED
		155794	B. WIN			03/18/2	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹					
STRATFORD RETIREMENT LLC					LEBE ST		
SIRAIF	JRD RETIREMEN	ILLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	Instructions for	Care" dated 2/12/13			requirements of the discharge	Ì	
	indicated the m	nedications the resident			summary and transfer form.		
		on, the name of			·		
	_				What measures will be put into		
		ame of the facility, that			place to ensure the practice does		
	_	sed to sign, and the			not recur?		
	signature of the	e nurse. There was no					
	other informati	on pertaining to status			All pending discharges will be		
	of resident with	n destination, diet, or			reviewed and monitored for		
		y. There was no			appropriate transfer/discharge		
		of chest x-ray or			documentation. The ADON or		
	tuberculin testi	·			designee will review the records 5		
	tuberculli testi	rig.			days per week as part of her		
					routine. She will bring any identifie	d	
		clinical record for			issues to the next scheduled		
	Resident #34 v	vas completed on			morning management		
	3/18/13 at 11:0	00 a.m. Diagnoses			interdisciplinary meeting for review		
	included, but w	vere not limited to,			and recommendations for follow-up).	
	Alzheimer's wi	th depression, anxiety					
		structive pulmonary			How will the corrective action be		
	disease.	structive pairionary			monitored to ensure the deficient		
	uisease.				practice does not recur and what		
	The forms titled	"Diagharma			QA will be put into place?		
	The form titled	<u> </u>					
		Care" dated 2/15/13			The ADON or designee will bring the		
	indicated the m	nedications the resident			results of the reviews to the monthl	У	
	was currently of	on, the name of			QA Committee meeting for review		
	resident, the na	ame of the facility, that			and recommendations. Any		
	-	sed to sign, and the			recommendation made by the		
		e nurse. There was no			committee will be followed up by		
	_	on pertaining to status			the ADON or designee and the		
					results will be brought to the next		
		n destination, diet, or			scheduled QA Committee meeting.		
		y. There was no			This will continue on an ongoing		
	documentation	of chest x-ray or			basis.		
	tuberculin testi	ng.					
	In an interview	with the Director of					

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PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED	
		155794	B. WING		03/18	/2013	
		1		ADDRESS, CITY, STATE, ZII	P CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		SLEBE ST			
	ORD RETIREMEN		CARMI	EL, IN 46032			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
PREFIX	1	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE HE APPROPRIATE	COMPLETION	
TAG	ł	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY))	DATE	
		18/13 at 1:30 p.m., she					
		discharge instructions					
		s the only place they					
		sfer information for the					
	resident.						

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155794	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/18/2013
NAME OF PROVIDER OR SUPPLIER STRATFORD RETIREMENT LLC			STREET . 2460 G	ADDRESS, CITY, STATE, ZIP CODE GLEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
R000410	completed within admission or upon forty-eight (48) to The result shall be induration with the and by whom admission of the process of the result during the promotes of the process of th	Noncompliance suberculin skin test shall be three (3) months prior to a admission and read at seventy-two (72) hours. It recorded in millimeters of a date given, date read, ministered and read. Who have not had a stive tuberculin skin test preceding twelve (12) line tuberculin skin testing at two-step method. If the two, a second test should min one (1) to three (3) rest test. The frequency of depend on the risk of erculosis. Who have a positive reaction skin test shall be required eray and other physical and mations in order to complete wiew and record lity failed to obtain 1st suberculosis skin test on, admission for 1 of 1 ared for admission for 1 of 1 ared for admission ng. (Resident #31 and n, the facility failed to all tuberculosis skin esidents reviewed for lin testing. (Resident	R000410	What corrective action will be taken by the facility? Reside #29, #30 and #31 will receive appropriate tuberculosis assessment. All resident recowill be audited for compliance regarding tuberculin skin test of positive, the tuberculosis screed. Any resident lacking sufficient documentation of series completion will have the vaccininstituted or the tuberculosis screen. This information will be recorded on the immunization record in the clinical record. How will the facility identify other residents having the potential to be affected by the	nt the rds or if en. the

State Form Event ID: CR9N11 Facility ID: 011151 If continuation sheet Page 54 of 56

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155794		B. WING		03/18/2013	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹		1			
OTDATEODD DETIDEMENT I I O					LEBE ST		
SIKAIR	STRATFORD RETIREMENT LLC			CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	#31 was reviev	ved on 3/18/13 at			same practice and what		
	11:20 A.M. Th	e resident was			corrective action will be take		
	admitted on 6/				All residents have the potentia	I to	
		10/12.			be affected by the alleged		
	The Ulas as	sticus December forms			deficient practice. Any resider		
		ation Record" form			lacking sufficient documentation		
		t step tuberculin skin			of series completion will have		
		nistered on 6/18/12.			vaccine instituted, along with t	ne	
	The date read	with the results were			appropriate series documentation. What measure	roe	
	not recorded o	n the form. A second			will be put into place to ensu		
	step test was r	ecorded as			the practice does not recur?	<u>16</u>	
	•	n 7/2/12. The date			Clinical records will be reviewed	- ⁴	
		esults were not			on admission and then added		
					the Tuberculin Testing Tracking		
	recorded on the	e torm.			Log Form. The ADON or	ĭ	
					designee will review the record	ds 5	
	In an interview	on 3/18/13 at 2:15			days per week as part of her		
	P.M., the Direct	ctor of Nursing			routine for 3 months and a		
	indicated she h	nad checked the MAR			pattern of compliance is		
	(Medication Ac	Iministration Record)			established. Once the 3 mont	-	
	•	imentation, but could			has been completed along with	h	
		e tests had been read.			the pattern of compliance, the		
	וווטנ ווווט נוומנ נוונ	e lesis nau been reau.			tracking log will be reviewed o	n a	
					monthly basis. The ADON or designee will bring any identifi	od	
		record for Resident			issues to the next scheduled	eu	
	#30 was reviev	ved on 3/18/13 at			morning management		
	10:15 A.M.				interdisciplinary meeting for		
					review and recommendations	for	
	An annual tube	erculosis skin test,			follow-up. How will the		
		nin the last year, was			corrective action be monitore	<u>ed</u>	
	not found.	iii tile last year, was			to ensure the deficient practi	<u>ce</u>	
	not lourid.				does not recur and what QA		
		0/40/40 + 0.45			will be put into place? The		
		on 3/18/13 at 2:15			ADON or designee will bring the	ne	
		tor of Nursing indicated			results of the reviews to the		
	an annual test	had not been done.			monthly QA Committee meetir	ng	
					for review and		
					recommendations. Any		
					recommendation made by the	.	
					committee will be followed up	DV I	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETI	ED	
		155794	A. BUILDING B. WING		03/18/20)13	
			_	T ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLI	ER		GLEBE ST			
STRATE	ORD RETIREMEN	THC		MEL, IN 46032			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI		(X5)	
PREFIX	, and the second	ENCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	COMPLETION	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG			DATE	
				the ADON or designee and results will be brought to the			
				scheduled QA Committee	ie riext		
				meeting. This will continue	e on an		
				ongoing basis.			
	3. The clinical	record was reviewed for					
		on 3/18/13 at 9:15 a.m.					
	Resident # 27 (3/10/13 at 7.13 a.m.					
	The documenta	4:					
		for Resident #29 indicated					
	she had receive	ed a 1st step tuberculin					
	(TB) test on 9/	19/12. There was no					
	documentation	of a 2nd step TB test					
	noted.	of a 2nd step 12 test					
	noted.						
	A						
		made on 3/18/13 at 1:40					
	_	ector of Nursing relating					
	to the 2nd step	TB test for Resident #29.					
	The Assistant I	Director of Nursing					
		3/18/13 at 4 p.m., she had					
		nformation to provide					
		B test for the above					
		D test for the above					
	resident.						

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